DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Date Issued: November 22, 2000

Operational Policy Letter (OPL) #: 2000.128

To:	**Current M+C Organizations**	**X**
	CHPP Demonstrations:	
	Evercare	**X**
	DoD (TriCare)	**X**
	SHMO I & II	**X**
	PACE	**X**
	Medicare Choices	**X**
	OSP Demonstrations:	
	MSHO	
	W.P.S.	
	HCPPs	
	Federally Qualified HMOs	
	Section 1876 Cost Plans	

Subject: Hospital Outpatient Department Encounter Data Requirements from the Balanced Budget Act of 1997 (BBA) - **DRAFT OPL Pending OMB Approval**

Effective Date: Date of Issuance

Implementation Date: April 1, 2001

Issue/Question:

How will the Health Care Financing Administration (HCFA) collect hospital outpatient encounter data?

Resolution/Answer:

Background

Section 1853(a)(3) of the Social Security Act requires the Secretary to implement a risk adjustment

methodology that accounts for variation in per capita costs based on health status. These data will be used in a comprehensive risk adjustment system that reflects diagnoses assigned both in ambulatory and inpatient sites of care. This comprehensive risk adjustment system is scheduled for implementation January 1, 2004.

The requirements for submission of hospital outpatient encounter data have been addressed (in draft form) in several meetings with selected health plans, as well as public meetings, to which all Medicare+Choice organizations (M+COs) were invited. Questions and answers generated from these meetings are shown in Attachment D.

I. GENERAL REQUIREMENTS

M+COs must submit hospital outpatient encounter data beginning April 1, 2001, for services rendered on or after January 1, 2001. Encounter data are required for all outpatient services for which hospitals would bill using the UB-92 form, including outpatient surgery, emergency room services, clinics, and X-ray services. The following services are excluded: durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); transportation services including ambulance services; and laboratory services.

M+COs must submit hospital outpatient encounter data for all services from both contracted and non-contracted facilities. M+COs must submit hospital outpatient data as early as possible after receipt of encounters from a hospital outpatient department, but at least on a monthly basis. This will assure that necessary corrections are made on a timely basis. M+COs should submit the encounter data to the front-end processor, Palmetto Government Benefits Administrator (PGBA).

Note that since the encounter system process for abbreviated UB92s is fundamentally different from the fee-for-service process, revenue codes will **not** be required and condition codes will **only** be required in a limited number of circumstances. Condition code 04 will be plugged by the front end processor.

II. TIMEFRAMES FOR SUBMISSION OF DATA

Deadlines for the submission of data are:

Services from:	**Services through:**	**Submission to HCFA Data Center no later than:**
January 1, 2001	June 30, 2001	November 9, 2001
July 1, 2001	June 30, 2002	September 6, 2002
July 1, 2002	June 30, 2003	September 5, 2003
July 1, 2003	June 30, 2004	September 3, 2004

III. SPECIFIC REQUIREMENTS

1. Electronic billing requirement

Outpatient encounter data must be submitted electronically for processing. Data can be transmitted using: a complete UB-92, complete ANSI 837 format or an abbreviated UB-92 format. These formats are described in section IV. Specific requirements for the abbreviated version are shown in Attachment A.

2. Data Completeness

M+COs must supply encounters that comply with Medicare coding requirements. The outpatient UB-92 requires M+COs to include International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9CM) diagnostic codes and HCFA Common Procedure Coding System (HCPCS) procedure codes in the appropriate fields.

In general, M+COs must submit encounter data for which:

X the coding reported on the encounter matches the coding reported by the hospital outpatient department to the plan; and,

X the coding is justified by the full medical record.

M+COs may wish to purchase and use the Outpatient Code Editor (OCE), which is used to edit HCPCS codes for validity, appropriateness (given a patient□s age and gender), and specificity. The OCE also checks for inappropriate fragmentation of procedure codes (often referred to as □unbundling□) and other Correct Coding Initiative (CCI) requirements. Using this software prior to submission will eliminate many issues related to encounters.

It is the M+CO□s responsibility to assure that all data elements required on the abbreviated or full versions of the UB-92 are present. For example, hospital outpatient departments may submit data to the M+CO using the plan□s own enrollment number to identify the beneficiary. It is then the plan□s responsibility to substitute the Medicare HICN (Health Insurance Claim Number) for the enrollment number. (Hospitals serving M+CO members will not necessarily have access to the Medicare HICN.)

3) Encounter data pricing

Encounters will be priced under the applicable methodology used in the □original□ Medicare program (also known as □traditional□ Medicare or □fee-for-service□ Medicare). For most outpatient hospital encounters, therefore, outpatient prospective payment system (PPS) pricing will be used. Drugs and biologicals will be priced as in fee-for-service if they are not included in the APC payment amount.

(The final regulation for the outpatient PPS can be found on the HCFA Web site at http://www.hcfa.gov/regs/hopps/default.htm.).

One of the OCE edits results in the denial of certain surgical and/or radiological procedures that are appropriately performed in an inpatient setting. Although these services will be denied, they will be processed and the diagnoses will be used for risk adjustment.

Outpatient hospital encounters are priced based on HCPCS. However, one type of encounter--influenza vaccines--also uses a code in the condition code field for accurate pricing. If M+COs do not include condition code A6 for pneumococcal/influenza vaccines in Record Type 41, Field #4 (see section 3604 of the manual, page 6-38), the encounter will be priced; however, it will not be priced at the higher amount that would have been assigned if code A6 were included in the condition code field.

4) Data validation

A sample of hospital outpatient encounters may be validated against hospital outpatient medical records to ensure the accuracy of diagnostic and/or procedure information. Reviews will be conducted by an independent contractor. M+COs will be provided with additional information as the process for these reviews is developed.

5) Certification

As a condition for receiving payments under the Medicare+Choice program, the M+CO agrees that its chief executive officer (CEO) or chief financial officer (CFO) must make a certification on Attachment B of its Medicare+Choice contract, based on best knowledge, information, and belief, that the encounter data the M+CO submits to HCFA are accurate, complete, and truthful. If the encounter data are generated by a related entity, contractor, or subcontractor of the M+CO, such entity, contractor or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data.

6) Data Edits

There are three stages of data editing. The M+CO will transmit the file to PGBA, as a subcontractor to AT&T Global Network Systems (Medicare Data Communications Network-- MDCN). Upon receipt at Palmetto, the data are checked against a series of □front-end□ edits. These edits check the validity of data, with edits including: correct file, batch, and claim record formats; appropriate type of data (numeric or alphanumeric) and correct lengths in specific fields; specific values for certain codes, such as diagnosis codes, procedure codes, and zip codes. Files, batches, and/or claims will be rejected for failure to pass the front-end edits. Rejected transactions will be reported to the M+CO as submitted, with codes indicating the reason for the rejection. The M+CO should correct these records and resubmit.

A second series of edits is performed by the Fiscal Intermediary Shared System (FISS). Once the

data have passed the front-end edits, they are passed on to the FISS edit process where the edits test for the consistency between field values, such as diagnosis and procedure codes. The edits also check against eligibility status. The actual resolution of an edit within FISS will be done by the Customer Service Support Contractor (CSSC)-- also PGBA, which is acting in a different capacity than under its front end contract with the MDCN to provide this and a number of other services. Medical review (MR), utilization review (UR), coverage policy, and Medicare Secondary Payer (MSP) edits are bypassed.

Within FISS, there is a program called Outpatient Code Editor (OCE) which contains a series of "bundling" edits. Specifically, the OCE applies HCFA's Correct Coding Initiative (CCI) edits. (These edits, with the exception of anesthesiology edits, are incorporated into the OCE software.) These edits are of two major types. One type, referred to as the comprehensive/component ("fragmentation) edits, applies to situations of code combinations where one reported code is a component of a more comprehensive code that is also reported. In those situations, only the more comprehensive code is paid. The other type, referred to as mutually exclusive edits, is applied to combinations of reported procedure codes where it is either improbable or impossible that the procedures would be performed together. Other unacceptable code combinations are also included. One such combination consists of one that represents a service "with" something and the other is "without" the same thing. In such cases, the CCI edit pays the lesser priced service. The application of these edits assures correct pricing of the encounter. Examples of some common FISS edits appear in Attachment B.

Records passing all these edits are sent to the Common Working File (CWF) host. Here data will again be subject to certain additional editing and, if there are no problems, the encounter data will be directed to the National Claims History (NCH) file.

The M+CO will receive reports from the HCFA Data Center for UB-92 claims that have gone to CWF but have not received a response as yet. They will also get reports on all claims that have finalized.

7) Foreign hospitals

For "foreign providers" (defined as providers not located in the U.S., Canada, or Mexico), M+COs may use the code: 990001.

8) Adjustment bills

Adjustment bills are the mechanism for changing a previously accepted (by CWF) bill. M+COs will be required to submit adjustment bills (via two separate transactions-- void and replace) in order to correct critical data on already accepted bills. Adjustment processing will also be available for abbreviated (and full) UB92s for inpatient services beginning April 1, 2001.

Full UB92 adjustments

Full UB-92s voiding or canceling a prior claim are designated by a three-digit code, 128, 138, 148, or 838, in Record type 40, Field #04. These codes indicate that the submission is an exact duplicate of an incorrect bill previously submitted. These are the same codes used for this purpose in fee-for-service Medicare.

Full UB-92 replacements are designated with 127, 137, 147, or 837 shown in Record type 40, Field #04. These are the same codes used for this purpose in fee-for-service Medicare.

Abbreviated UB92 adjustments

Abbreviated UB-92s voiding or canceling a prior claim are designated by a three-digit code, 12X, 13X, 14X, or 83X shown in Record type 40, Field #04. These special codes are required in order to designate that the void/cancellation is in the abbreviated format. The codes indicate that the submission is an exact duplicate of an incorrect bill previously submitted using the abbreviated format.

Abbreviated UB-92 replacements are designated with 12Y, 13Y, 14Y, or 83Y shown in Record type 40, Field #04. These special codes are required in order to designate that replacements are in the abbreviated format.

Miscellaneous adjustment requirements

Once a full UB-92 has been fully processed, an abbreviated UB-92 may not be submitted as a replacement for the same encounter. If M+COs wish to change or correct the encounter on a full UB-92, they must either submit a correction in the full format, or cancel the entire full UB-92 and then submit an abbreviated UB-92.

However, a number of fields to which many adjustments are made on the original Medicare side are not be included in the abbreviated UB-92, if these fields are not required for determining a risk factor or pricing the services. Thus, replacement UB-92s are limited to diagnostic and procedure codes, dates of service, provider ID, and other critical fields.

9) Duplicate encounters

Duplicate encounters (either inpatient or outpatient) should not be billed by MCOs once the encounter has passed the front-end edits. Duplicate encounters that have erroneously been submitted will be denied.

IV. MCO REQUIREMENTS

Billing Options/Data Requirements

M+C organizations may choose one of three options for submitting outpatient hospital encounter data. The first option is to submit outpatient encounter data using the complete UB-92, version 6.0. The second is to submit the ANSI ASC X12 837 format (abbreviated as the "ANSI 837" format in the remainder of this document). The third option is to use an abbreviated UB-92, version 6.0, data set. Specific requirements for all three options are described below. For all options, the M+CO may populate such fields as the patient's name, birth date, and sex using its internal databases if these were not accurate or present on the hospital bill. The encounter bill must, however, reflect the date of service, procedures, and diagnoses assigned to your enrollee by the hospital.

a) OPTIONS 1 and 2-- The organization submits a complete UB-92 or a complete ANSI 837 to the HCFA Data Center. The M+CO may take a Medicare-compliant, full UB-92, version 6.0 received from a hospital and submit it to HCFA as encounter data. Medicare-compliant bills are defined as bills that contain all required fields.

Before transmitting this encounter to HCFA, M+COs must:

1. Check to make sure that the appropriate bill type is present. Type of bill is a three-digit code. The first digit is 1, indicating hospital or 8, indicating special facility (i.e., non-PPS hospital). The second digit is 2, indicating hospital based, 3, indicating outpatient, or 4, indicating other. **The third digit may be any appropriate code as indicated in the Medicare Intermediary Manual (3604) (pp 6-26 through 6-28). This third digit may be used to correct previously submitted full UB-92 encounters.** (A full UB-92 void/cancellation of a prior bill employs an 8 in the third digit, indicating that the submission is an exact duplicate of an incorrect bill previously submitted. Full UB-92 replacements employ a 7 in the third digit.)

2. Add your M+CO identification number ("H" number) to the UB-92/ANSI 837. The exact placement (or field) for the M+CO identification number depends upon whether the electronic UB-92 or ANSI 837 format is used.

3. Condition codes are only required to correctly price a specific HCPCS code. If that occurs, then the condition code should be submitted (e.g., pneumococcal/influenza vaccines cited above.)

4. You may remove any patient control number filled in by the hospital and replace it with the patient control number you wish to keep for tracking the data. If you do remove the patient control number used by the hospital, maintain a crosswalk between the hospital patient control number and the number added by the M+CO.

If the hospital has not provided charges, you do not need to do so. The front-end processor will fill in the default value of $ 1.00 regardless of whether or not actual charges are present.

b) OPTION 3 The organization submits an abbreviated UB-92, version 6.0 to HCFA. This encounter data must reflect a service reported by the hospital outpatient department, but is a subset of data that would be submitted on the full UB-92.

Appendix A shows the format and the data elements to be used by the M+CO to transmit the abbreviated hospital outpatient encounter data set to HCFA. The data set reflects the specific requirements that must be followed in order for the abbreviated UB-92 to pass the required edits. These requirements cannot be waived by HCFA. Abbreviated UB-92s for outpatient service encounters will be recognized when the following codes are used:

1. Type of bill is a three-digit code. The first digit is 1, indicating hospital or 8, indicating special facility (i.e., non-PPS hospital). The second digit is 2, indicating hospital based, 3, indicating outpatient, or 4, indicating other. **The third digit must be Z (indicating abbreviated format), Y (indicating an abbreviated replacement), or X (indicating cancellation of an abbreviated bill).**

2. The M+CO identification number must be included (Record type 31, Field #15).

3 Condition codes are only required to correctly price a specific HCPCS code. If that occurs, then the condition code should be submitted (e.g., pneumococcal/influenza vaccines cited above.)

4. You may remove any patient control number filled in by the hospital and replace it with the patient control number you wish to keep for tracking the data. If you do remove the patient control number used by the hospital, maintain a crosswalk between the hospital patient control number and the number added by the M+CO.

As with full UB92s or ANSI 837s, if the hospital has not provided charges, you do not need to do so. Also, the front-end processor will fill in the default value of $ 1.00 regardless of whether or not actual charges are present. Note that revenue codes are not required for abbreviated UB92 submissions.

Contact: HCFA Regional Office Managed Care Staff

This OPL was prepared by the Center for Health Plans and Providers.

Attachment A

UB-92 Abbreviated Outpatient Hospital Encounter Data
Version A6.0

UB 92 Rec Type	Field No.	Field Name	Length	Picture	Paper Form Item Number
01	1	Record Type '01'	2	XX	
01	2	Submitter EIN	10	9	
01	3	Multiple Provider Billing File Indicator	1	9	
01	9	**Submitter Name**	21	X	1
01		**Submitter Address**			1
	10	**Address**	18	X	1
	11	**City**	15	X	1
	12	**State**	2	XX	1
	13	**ZIP Code**	9	X	1
01	16	**Submitter Telephone Number**	10	9	1
01	17	File Sequence and Serial Number	7	X	
01	18	Test/Production Editor	4	X	
01	20	**Processing Date ("Date Bill Submitted" on HCFA 1450)(CCYYMMDD)**	8	9	
01	22	Version Code (060)	3	X	
10	1	Record Type '10'	2	XX	
10	2	Type of Batch/Bill (12Z, 13Z, 14Z, 83Z)	3	XXX	4
10	3	Batch Number	2	99	
10	6	**National Provider Identifier (Medicare ID)**	13	X	51
20	1	Record Type '20'	2	XX	
20	3	Patient Control Number	20	X	3
20	4	**Last Name**	20	X	12
20	5	**First Name**	9	X	12
20	7	**Sex (F,M)**	1	X	15
20	8	**Birth Date (CCYYMMDD)**	8	9	14
20		**Statement Covers Period Date**			
	19	**From Date (CCYYMMDD)**	8	9	6
	20	**Through Date (CCYYMMDD)**	8	9	6
30	1	Record Type '30'	2	XX	
30	2	Sequence Number	2	99	
30	3	Patient Control Number	20	X	3
30	7	**HIC Number**	19	X	60
31	1	Record Type '31'	2	XX	
31	2	Sequence Number	2	99	

31	3	Patient Control Number	20	X	3
31	15	**Contract Number**	5	X	
40	1	Record Type '40'	2	XX	
40	2	Sequence Number	2	99	
40	3	Patient Control Number	20	X	3
40	4	Type of Batch/Bill (12Z, 13Z, 14Z, 83Z)	3	X	4
41	1	Record Type '41'	2	X	
41	2	Sequence Number	2	99	
41	3	Patient Control Number	20	X	3
41	4-13	**Condition Code (occurs 10 times), "04"-HMO enrollment**	2	X	24-30
61	1	Record Type '61'	2	X	
61	2	Sequence Number	3	9	
61	3	Patient Control Number	20	X	3
61	6	**HCPCS Procedure Code**	5	X	44
61	7	Modifier 1 (HCPCS & CPT-4)	2	X	44
61	8	Modifier 2 (HCPCS & CPT-4)	2	X	44
61	9	**Units of Service**	7	9	46
61	11	Outpatient Total Charges	8	9	47
61	12	Outpatient Noncovered Charges	8	9	48
61	13	**Date of Service (CCYYMMDD)**	8	9	45
70	1	Record Type '70'	2	XX	
70	2	Sequence Number	2	99	
70	3	Patient Control Number	20	X	3
70	4	**Principal Diagnosis Code**	6	X	67
70	5-12	**Other Diagnosis Code (occurs 8 times)**	6	X	68-75
90	1	Record Type '90'	2	XX	
90	3	Patient Control Number	20	X	3
90	4	Physical Record Count	4	9	
90		Record Type nn Count	2	9	
	5	Record Type 2n Count	2	9	
	6	Record Type 3n Count	2	9	
	7	Record Type 4n Count	2	9	
	9	Record Type 6n Count	4	9	
	10	Record Type 7n Count	2	9	
95	1	Record Type '95'	2	X	
95	5	Type of Batch/Bill (12Z, 13Z, 14Z, 83Z)	3	X	
95	6	Number of Claims	6	9	
99	1	Record Type '99'	2	X	
99	2	Submitter EIN	10	9	
99	5	Number of Batches Billed This File	4	9	

Notes: Detailed editing is limited to Field Names in **bold**. However, note the following:

1. Field names not in bold are required to be present; and

2. Information contained on record types 90 and 95 must match the information transmitted.

The differences between the Version 5.0 and 6.0 (for the abbreviated data set) are:

Record Type 01, Field 22 Version Code (060) instead of (050).

Record Type 61, Field 2 Sequence Number: **version 5** had length 2, picture 99, and **version 6** has length 3, picture 9.

Record Type 61, Field 4 Revenue Code-1,2,3: **version 5** had length 56 and **version 6** has length 55.

Record Type 90, Field 4 Physical Record Count: **version 5** had length 3 and **version 6** has length 4.

Record Type 90, Field 9 Record Type 6n count: **version 5** had length 2 and **version 6** has length 3.

Attachment B

Examples of Edits on Abbreviated UB-92 Outpatient Hospital Encounter Data

1. Each record contains all required field listed on Attachment A.
2. Processing Date field is 8 characters and is equal to or less than the current date.
3. National Provider Identifier field is 13 characters and contains all numbers (NOTE: Until NPIs are assigned, this field will contain the 6-digit provider number).
4. Sex field is 1 character and contains either F or M.
5. Date of Birth field is 8 characters, contains all numbers, and is less than the current date.
6. Date of Service field is 8 characters, contains all numbers, and is equal to or less than the current date.
7. From Date field is 8 characters, contains all numbers, and is equal to or greater than the Date of Service field.
8. Through Date field is 8 characters, contains all numbers, and is equal to or greater than the From Date/Service Date.
9. Contract Number field contains 5 characters.
10. Type of Bill field is 12Z, 13Z, 14Z, or 83Z.
11. Condition Code field is 2 characters and contains at least an "04."
12. Principal Diagnosis Code field contains 3 - 6 characters and is a valid ICD-9-CM code.
13. If present, Other Diagnosis Code field contains 3 - 6 characters and is a valid ICD-9-CM code.
14. HCPCS Procedure Code is a valid HCPCS code.
15. Modifiers, if present, must be valid and must be appropriate to the HCPCS.
16. HIC Number field contains 10-12 characters and is valid.
17. Revenue codes and centers must be valid codes.

Attachment C

Information on the Required Fields for the UB-92/ANSI 837 Record

1. The following are fields that are not required on the full UB-92 format for outpatient hospital encounters:

UB-92 Record Type	Field Number(s)	Paper Reference	Field Name
10	4	5	Federal tax number
30	20	7	Covered days
30	21	8	Noncovered days
30	22	9	Coinsurance days
30	23	10	Lifetime reserve days
20	9	16	Patients marital status
20	17	17	Admission date/start of care
20	18	18	Admission hour
20	10	19	Type of admission
20	22	21	Discharge hour
20	25	23	Medical record number
		43	Revenue description
30	17	53	Assignment of benefits certification indicator
20, 30	24, 26	53	Estimated amount due

2. The following fields are not included in the abbreviated UB-92 for outpatient hospital, but are required (when applicable) if you choose to submit a full UB-92 format.

UB-92 Record Type	Field Number(s)	Paper Reference	Field Name
20	12-16	13	Patient address
20	11	20	Source of admission
20	21	22	Patient status
30	5,8	50	Payer identification
30	16	52	Release of information
?	?	54	Prior payments (may be dummied equal to 0)
30	12-14	58	Insured□s name
40	8-23	32-35	Occurrence codes and dates
40	28-33	36	Occurrence span code and dates

41	16-39	39-41	Value codes and amounts
61	4,5		Revenue code
80	5	82	Attending/referring physician I.D.

Attachment D

Questions and Answers about Encounter Data Submission using the Outpatient Hospital UB-92 Form

Question: When we submit outpatient hospital encounter data, how do we identify (distinguish it) from inpatient hospital encounter data? Is there some field in the UB-92 format?

Answer: The encounter is identified as an outpatient encounter through the field labeled "type of batch/bill type." This code appears several times on the UB-92, including at Record Type 10, Field 2; Record Type 40, Field 4; Record Type 95, Field 5.

Question: What are all the possible codes that identify the type of outpatient bill for abbreviated encounters?

Answer: The four basic codes are 12Z, 13Z, 14Z, and 83Z. The first digit indicates type of facility: 1=hospital and 8=special facility or hospital ASC surgery. The second digit indicates classification: 2=hospital based or inpatient (Part B), 3=outpatient, and 4=other (Part B) (includes referred diagnostic services). The third digit, Z, will indicate that this is managed care encounter data and submitted on an abbreviated format. In addition, an X in the third digit indicates a void/cancellation of a previously submitted abbreviated bill, and a Y indicates a replacement of a previously submitted abbreviated bill. Note that the third digit is different for full UB-92 encounters.

Question: If the hospital sending the data fails to provide the patients name, birth date, and/or sex, may health plans populate these fields based on their membership files?

Answer: Yes. The plan should not, however, fill in missing information that indicates the services performed the date of service, or the diagnoses assigned by the physician in the hospital. Instead, the plan should obtain documentation from the hospital that contains this information and may use this documentation as the basis for filling in the missing information.

Question: If HCFA is bypassing Medicare Secondary Payer (MSP) edits, can record types 30 and 31 be eliminated from the abbreviated UB-92 format?

Answer: No. Even though these record types are labeled "third party data," they are not only applicable to MSP. Record type 30 contains the Health Insurance Claim (HIC) number, which we use to identify the Medicare beneficiary. Record type 31 contains the contract number, which we use to identify the M+CO in which the beneficiary was enrolled.

Question: Which field can be used by the M+CO as an internal Patient Control Number to track data that are submitted?

Answer: The hospital generally will assign a patient control number to the claim. This number will appear in multiple fields: Record Type 20, Field 3; Record Type 30, Field 3; Record Type 31, Field 3; Record Type 40, Field 3; Record Type 41, Field 3; Record Type 61, Field 3; Record Type 70, Field 3; Record Type 90, Field 3.

When the M+CO receives an outpatient hospital encounter from the hospital, it can substitute its patient control number for that supplied by the hospital. You must maintain an internal crosswalk between the hospital patient control number and your internal tracking number. This field has space for 20 characters.

Question: The format implies that you want both the UB-92 revenue code and a HCPCS/CPT procedure code. Is this correct?

Answer: You do not need to submit the revenue code, only the HCPCS code is needed to identify the service.

Question: What is the appropriate format for the revenue code?

Answer: See answer above.

Question: What should we do if the hospital sends us a bill without the charges?

Answer: If the hospital has not filled in charges, you do not need to do so. The front-end processor will fill in the default value of $ 1.00 regardless of whether or not actual charges are present.

Question: Will the processing systems accept "homegrown" codes (codes developed by an M+CO to identify types of care provided and diagnoses)?

Answer: Do not use these types of codes. The system will read these and error, sending the encounter back to you for correction. You must use the same diagnosis and procedure codes that HCFA uses for original Medicare in order for your encounter data to be processed and to assign risk scores to your enrollees.

Question: Why are the submission dates for the different data types different? Will HCFA move to a coordinated schedule in the future?

Answer: The dates are staggered to allow for training and programming changes on the different types of data. In the future, all encounter data will be collected on the same schedule.

Question: Should we submit claims for encounters that we denied?

Answer: In general, yes. Providing the most complete information will allow us to capture all of the diagnoses recorded by your providers without regard to what you paid for because of coverage or contractual payment rules. We will use the diagnostic information from encounters to determine beneficiary risk score. If, however, you believe that the providers information does not reflect care provided to your member, do not submit the encounter to HCFA.

The encounter should be substantiated by the hospitals medical record. If your Medicare+Choice organization receives an incorrect code in a critical field (i.e. a diagnosis code, procedure code, or date of service) you should ask the provider to provide documentation to allow correction and resubmission of the encounter.

Question: To the extent that an M+CO uses freestanding surgi-centers, how will this data be captured, if at all? Will this data be picked up only if the surgi-center is hospital owned?

Answer: At this time, we will not be collecting encounters from freestanding ambulatory surgical centers (ASCs). We expect that we will, however, receive encounters from hospital-based surgical centers as part of the data collected through the UB-92 for hospital outpatient services. We expect that the diagnosis data for services rendered in ASCs will ordinarily be captured on the physician encounters submitted for those services.

Question: How are new procedures and new technologies coded?

Answer:. One aspect of the outpatient PPS involves the recognition of new technology items and services as discrete payment groups under the PPS. A document posted on the HCFA Web site (http://www.hcfa.gov/medicare/2apsnoti.htm) describes the process that will be used to (1) identify those items and services that represent new technologies, and (2) establish codes for them through the HCFA Common Procedure Coding System (HCPCS) that will be used to initiate payment and process claims for such items. In cases where codes for new technologies and new procedures are not yet available, the "Other Procedure" code in the most appropriate clinical group can always be used. Use of the "Other Procedure" codes will generate a payment amount under the outpatient PPS system.

Question: Should anatomical/pathological services be submitted?

Answer: They should not be submitted.